

**COMPLAINT FORM**

Person(s) Requesting Investigation

Person To Be Investigated

\_\_\_\_\_  
Name\_\_\_\_\_  
**Physician's Full Name (First and Last)**\_\_\_\_\_  
Address\_\_\_\_\_  
Physician's Address\_\_\_\_\_  
Phone Number\_\_\_\_\_  
Physician's Phone Number

(Give a brief statement of the facts with dates. Use additional sheets as necessary with copies of relevant documents.

**PLEASE SEND COPIES ONLY. MATERIALS WILL NOT BE RETURNED.)**

PATIENT'S FULL NAME: \_\_\_\_\_

(It would be helpful if you could include the patient's date of birth and Social Security number.)

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

I authorize the Georgia Composite State Board of Medical Examiners to use this form and the information submitted with this form when conducting an investigation or acquiring medical records. I hereby authorize the Board to release a copy of my complaint to the physician involved/mentioned in the complaint.

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**Signature** of Person Requesting Investigation**Date**

Mail to: Composite State Board of Medical Examiners, 2 Peachtree St, NW. 36<sup>th</sup> floor, Atlanta, GA 30303.

## Waiver Form

I, \_\_\_\_\_, having filed a  
(Complainant's Name)  
complaint with the Georgia Composite State Board of Medical Examiners dated  
\_\_\_\_\_ against \_\_\_\_\_ who is licensed as a  
(Licensee's Name)  
\_\_\_\_\_.  
(License Type)

Hereby waive any privilege which I may have with respect to the licensee against whom I have made complaint, so that the licensee may respond to my complaint and provide confidential information to the Board pertaining to the matters raised in my complaint, and

Authorize the release of the information in my complaint to those individuals who, in the sole discretion of the Board, its staff or legal counsel, may be necessary to conduct a full and fair investigation of the complaint, and

Authorize the use of my name in the investigation of my complaint by the Board, its professional staff, investigators, and legal counsel, and

Hereby give my consent for the Georgia Composite State Board of Medical Examiners to be given access to any and all of my personal, medical/psychiatric/psychological/alcohol treatment/drug treatment records for review and copying.

This consent is subject to revocation at any time upon written notice by the patient named herein to the above custodian of record, except to the extent that action has been taken in reliance upon this consent.

### RETURN TO:

Composite State Board of Medical Examiners  
Attn: Complaints Unit  
2 Peachtree Street, N.W., 36<sup>th</sup> Floor  
Atlanta GA 30303  
Phone: (404) 657-6487

I authorize the Georgia Composite State Board of Medical Examiners to use this form if contacting the physician and/or conducting an investigation.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date